Testimony

Evidence on Home Visiting and Suggestions for Implementing Evidence-Based Home Visiting Through MIECHV

Addendum

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Evidence on Home Visiting and Suggestions for Implementing Evidence-Based Home Visiting Through MIECHV[2]

Before the Committee on Ways and Means
Subcommittee on Human Resources
United States House of Representatives

April 16, 2014

The subsequent question and answer found in this document was received from the Committee for additional information following the hearing on April 2, 2014 and were submitted for the record.

Response to Question from Chairman Dave Reichert, Subcommittee on Human Resources, Committee on Ways and Means

Thank you for the opportunity to testify before the Ways and Means Subcommittee on Human Resources on April 2. In your letter of April 4, you asked me to respond to this follow-up inquiry:
QUESTION:

Ensuring MIECHV Program Models Are Implemented Effectively

In your written and oral testimony, you pointed out that it's important for programs like MIECHV to focus funding on interventions that have been proven to work, instead of specifying what types of features a program should have. In your written testimony you go even further, saying you believe "consideration should be given to whether ongoing funding to particular states should be tied more closely to the state's implementation performance."
Under the current program structure, states receive funding to use on models that are based on evidence and that have shown success in high-quality studies. However, it's not clear that we know how well states are implementing the models they choose to administer. How might we implement a suggestion like yours, where the federal government also analyzes the state's performance in implementing the model successfully? Are there other programs that do this that we could review?

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[2] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT407z1.html.

ANSWER:

My suggestion to tie state funding more closely to a state's implementation performance was oriented toward improving the monitoring of implementation indicators in addition to monitoring fidelity to evidence-based program models.

Fidelity refers to the degree to which an intervention is implemented as it was prescribed in the evidence-based practice protocols by the program developers. Implementation is the entire set of activities required to successfully put into place an evidence-based program and includes fidelity along with other implementation outcomes such as costs, and recruitment and retention rates of clients (Proctor et al., 2011).

Regarding fidelity, the MIECHV program currently recognizes the importance of grantees delivering evidence-based models with fidelity and requires grantees to demonstrate fidelity as follows:

> "To ensure that the required statutory distribution is maintained, HRSA requires that all MIECHV programs demonstrate that they are being delivered in conformity with the approved service delivery models. This fidelity is demonstrated by programs that have the requisite designation and/or approval from a model developer to provide evidence-based home visiting services. MIECHV-funded programs must maintain the requisite designation and/or approval from the model developer while receiving MIECHV funding." [See MIECHV guidance at: http://ersrs.hrsa.gov/ReportServer?/HGDW_REPORTS/FindGrants/subrptEHB_GranteeFindProgramDesc&rc:ToolBar=false&theWhere= and PROG_ACTIVITY_CD='X02'].

It is not clear how well different models ensure fidelity, however. In fact, on the MIECHV evidence-based model website (http://homvee.acf.hhs.gov/ImpOverview.aspx), a summary table for the models indicates that five of the 14 evidence-based models do not have fidelity standards for local implementing agencies and three of the 14 do not have a system for monitoring fidelity.

There may be opportunities to improve the monitoring of MIECHV grantees' evidence-based model implementation in areas in addition to fidelity. Implementation performance is typically monitored using indicators that capture how well an organization delivers a service. Measuring implementation performance is valuable, because it indicates whether services are being delivered as intended, reaching target participants, being delivered with desired timeliness and frequency, and meeting other assurances that an evidence-based program is being delivered in a way that has the best chance of realizing the outcomes achieved in the model program

evaluations.[3] Examples of the types of indicators that may be used for this purpose in the home visiting field are number of families served, number of home visits provided, family drop-out rates, home visitors completing the model program training, and others.

Currently MIECHV grantees report a great deal of information as part of their award. They report a small number of process measures as part of the Demographic and Service Utilization Data for Enrollees and Children Form (available at: http://mchb.hrsa.gov/programs/homevisiting/ta/resources/enrolleeschildrenform.pdf). Grantees also provide a brief performance report, which includes explaining reasons for delays or unusually high unit costs (described here: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=a5e0bcbce193608ad376c11cec960a54&n=45y1.0.1.1.49.3&r=SUBPART&ty=HTML#45:1.0.1.1.49.3.18.19). Finally, MIECHV grantees also report a large number of outcome measures for participating children and families (see: http://mchb.hrsa.gov/programs/homevisiting/ta/resources/guidanceoct2012.pdf).

However, there are opportunities for improvement in specifically capturing *implementation* measures in two areas.

First, there appear to be ways to refine the indicators reported to improve their utility in communicating whether grantees are engaging in the desired quantity and quality of home visiting implementation. That is, while MIECHV grantees currently report a large number of indicators, we want to ensure that they are reporting the *right* indicators. This may not require an increase in the amount of information reported but rather modest improvements in the indicators reported for the purposes of assessing implementation performance.

Second, it is not only the collection of appropriate indicators that is important, but it is also necessary to use them explicitly to improve performance of grantees. Specifically, just as funding evidence-based models raises the chances that MIECHV funds will have their intended impact, so does funding grantees that can deliver evidence-based models *well*. It is reasonable to expect that the first phase of MIECHV would be a learning and planning phase for many states and other grantees (Fixsen et al., 2001) as research demonstrates that initiating a new program requires adequate time and community investment to ensure implementation success. However, in later phases of MIECHV, we may be able to promote the effectiveness of the MIECHV program by directing technical assistance to grantees that are not able to meet implementation objectives (e.g., recruitment goals and retention rates) or eventually redirecting funding only to grantees that

[3] This brief description of process evaluation from the federal Substance Abuse and Mental Health Services Administration provides a good overview of process evaluation: http://captus.samhsa.gov/access-resources/using-process-evaluation-monitor-program-implementation.

are able to serve target numbers of families, maintain high rates of family retention, meet the workplan objectives of expansion or development grants, or attain other measures of implementation performance. As an example, when funding evidence-based adolescent substance abuse treatment, the Substance Abuse and Mental Health Services Administration (SAMHSA) has used implementation performance indicators to identify grantees that need additional technical assistance to improve their implementation, and performance information was also considered in awarding future grants (Godley et al., 2011).

Please let me know if I can provide further information on this issue.

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